INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Federally Qualified Health Centers and Rural Health Clinics

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: December 15, 2016	Scheduled update	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: February 13, 2017	*Core*MMIS update	FSSA and HPE
2.0	Policies and procedures as of May 1, 2017 Published: September 12, 2017	Scheduled update	FSSA and DXC
3.0	Policies and procedures as of August 1, 2018 Published: February 14, 2019	Scheduled update	FSSA and DXC
4.0	Policies and procedures as of October 1, 2019 Published: December 3, 2019	Scheduled update	FSSA and DXC
5.0	Policies and procedures as of October 1, 2020 Published: November 17, 2020	Scheduled update: • Edited and reorganized text as needed for clarity • Updated the list of qualifying providers in the *Rendering Providers* section and added a note regarding provider enrollment • Clarified notification procedures in the *Termination of FQHC or RHC Status* section • In the *FQHC and RHC Encounters* section, updated the frequency of the Myers and Stauffer procedure code list review • Clarified information in the *Hospital Services* section • Clarified in the *Medicaid Rehabilitation Option Services* section that claims for MRO services provided by facilities enrolled as both an FQHC and a CMHC must follow normal MRO billing procedures	FSSA and Gainwell

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Federally Qualified Health Centers and Rural Health Clinics

*Note: The information in this module applies to Indiana Health Coverage Programs (IHCP) services provided under the **fee-for-service (FFS)** delivery system. For information about services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise services – providers must contact the member's managed care entity (MCE) or refer to the MCE provider manual. MCE contact information is included in the IHCP Quick Reference Guide available at in.gov/medicaid/providers.*

For updates to information in this module, see IHCP Banner Pages and Bulletins at in.gov/medicaid/providers.

Introduction

Federally qualified health centers (FQHCs) and rural health clinics (RHCs) are facilities designated to provide healthcare services to medically underserved urban and rural communities. FQHCs receive government grants, which help them provide primary care services to all patients, regardless of their ability to pay. FQHCs and RHCs have increased the use of nonphysician practitioners, such as physician assistants and nurse practitioners, in rural areas.

The Indiana Health Coverage Programs (IHCP) provides reimbursement for medical care provided to its members in FQHCs and RHCs.

Provider Enrollment Considerations

IHCP requirements for FQHC and RHC enrollment are described in the following sections. See the *Provider Enrollment* module for more information about enrolling as an IHCP provider and updating provider information on file.

Federally Qualified Health Centers

FQHCs receive funds through the *Public Health Service (PHS) Act* and receive FQHC status from the Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services. For IHCP reimbursement purposes, FQHCs and FQHC look-alikes are treated the same. For information regarding this process, contact the Indiana Primary Health Care Association at (317) 630-0845 or info@indianapca.org.

To enroll as an FQHC with the IHCP, providers must submit a copy of the Centers for Medicare & Medicaid Services (CMS) approval letter verifying FQHC status, along with their completed application, to the IHCP Provider Enrollment Unit.

The provider must also submit the proper financial documents to Myers and Stauffer LC, the IHCP rate-setting contractor, to have a reimbursement rate determined for the FQHC. Myers and Stauffer forwards the rate document to the Provider Enrollment Unit so the encounter rate can be loaded into the Core Medicaid Management Information System (*Core*MMIS).

Rural Health Clinics

RHC services are defined in *Code of Federal Regulations 42 CFR 405.2411* and *42 CFR 440.20*. RHCs receive Medicare designation through the CMS. Clinics must contact the Indiana State Department of Health (ISDH) to request RHC status for the IHCP.

The IHCP requires all RHCs to submit finalized (reviewed or audited) cost reports and copies of their Medicare rate letters to Myers and Stauffer. For more information about becoming an RHC under the IHCP, contact the ISDH at (317) 233-1325 or (317) 233-7474, the Indiana Primary Health Care Association at (317) 630-0845, or other practice consultants.

Rendering Providers

The IHCP reimburses FQHCs and RHCs for valid encounters with the following qualifying practitioners:

- Physician
- Physician assistant
- Advanced practice registered nurse (APRN)
- Clinical psychologist
- Clinical social worker
- Clinical addiction counselor*
- Marriage and family therapist*
- Mental health counselor*
- Dentist
- Dental hygienist
- Podiatrist
- Optometrist
- Chiropractor

All FQHC and RHC qualifying practitioner specialties that are eligible for IHCP enrollment must be enrolled in the IHCP as rendering providers, and their Provider IDs and National Provider Identifiers (NPIs) must be linked to the FQHC or RHC group enrollment.

Qualifying practitioners with specialties that are **not** eligible for IHCP enrollment must use an IHCP-enrolled supervising practitioner NPI for the rendering provider on the claim, and must include the appropriate midlevel practitioner modifier with the procedure codes for the services rendered.

> *Note: To find out if a qualifying practitioner for FQHC or RHC encounters is eligible for IHCP enrollment, check the IHCP Provider Enrollment Type and Specialty Matrix at in.gov/medicaid/providers.*

When a rendering provider is no longer associated with the FQHC or RHC, the clinic must notify the IHCP Provider Enrollment Unit in writing or via the *Provider Maintenance* page of the Provider Healthcare Portal (Portal) so that the information on file for the clinic provider is current.

* *Effective for dates of service on or after October 1, 2020.*

Change in Scope of Services

The IHCP understands that changes may occur in the scope of FQHC and RHC services. The IHCP considers changes in scope of services on a case-by-case basis, when providers meet filing requirements with Myers and Stauffer prior to the occurrence of a planned change in scope of services. The FQHC or RHC must, on their own behalf, correspond with Myers and Stauffer to complete the change in scope of services. For more information, see the *Indiana FQHC/RHC Change in the Scope of Service Guidelines*, accessible from the Myers and Stauffer website at mslc.com.

Each time an FQHC or RHC facility expands or decreases its scope of service and receives an adjustment to its encounter rate, Myers and Stauffer must forward the new rate letter to the IHCP Provider Enrollment Unit to ensure that reimbursement remains accurate.

Termination of FQHC or RHC Status

When a clinic's FQHC or RHC status is terminated, notifications are typically made as follows:

- Termination of FQHC status:
  - The CMS notifies the Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP).
  - The FSSA OMPP then notifies the IHCP Provider Enrollment Unit.
- Termination of RHC status:
  - The CMS notifies the clinic.
  - The provider must send a copy of the termination to the ISDH.
  - The ISDH then forwards the termination notice to the IHCP Provider Enrollment Unit.

Until FQHC or RHC status is reinstated, the provider must enroll in the IHCP as a medical clinic. Failure to do so will result in disenrollment as a provider and loss of any managed care members assigned to primary medical providers (PMPs) linked to that location.

Covered FQHC and RHC Services

The IHCP reimburses FQHCs and RHCs for services – and supplies incidental to such services – that the IHCP would otherwise cover if furnished by a physician or incidental to a physician's services. The IHCP considers any ambulatory service included in the Medicaid State Plan to be a covered FQHC or RHC service, if the FQHC or RHC offers such a service. FQHCs and RHCs are subject to the same prior authorization requirements as other IHCP providers.

The IHCP reimburses FQHCs and RHCs for services to homebound individuals only in the case of FQHCs and RHCs located in areas with shortages of home health agencies, as determined by the FSSA.

FQHCs and RHCs can provide preventive services and encounters, care coordination, and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)/HealthWatch services (see the *Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)/HealthWatch Services* module).

For information on telemedicine services provided by FQHCs and RHCs, see the *Telemedicine and Telehealth Services* module.

FQHC and RHC Billing and Reimbursement

In accordance with Section 702 of the *Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000* (BIPA), the IHCP implemented a prospective payment system (PPS) for reimbursing FQHCs and RHCs for IHCP-covered services. FQHCs and RHCs receive a facility-specific PPS rate determined by Myers and Stauffer. Myers and Stauffer forwards the specific PPS rate information to the IHCP fiscal agent, and the Provider Enrollment Unit loads the applicable PPS rate for reimbursement of Healthcare Common Procedure Coding System (HCPCS) code T1015 – *Clinic, visit/encounter, all-inclusive* to the specific provider enrollment file for reimbursement of fee-for-service (FFS) FQHC and RHC claims.

> *Note: IHCP-enrolled FQHCs must submit an Indiana Medicaid Cost Report annually, which is used in establishing their PPS rate, as well as when reviewing any requests for a change in scope of service. Instructions for completing the FQHC cost report and filing it with the State are available in the FQHC Cost Report Instructions and Manual on the Myers and Stauffer website at mslc.com.*

The following subsections provide **FFS** billing and reimbursement information for FQHC and RHC providers. For general FFS billing instructions, see the *Claim Submission and Processing* module. For FQHC and RHC claims submitted under the **managed care** delivery system, see the *Managed Care Considerations* section.

FQHC and RHC Encounters

A valid FQHC or RHC encounter is defined as a face-to-face visit (either in person or via telemedicine) between an IHCP member and a qualifying practitioner (see the *Rendering Providers* section) at an FQHC, RHC, or other qualifying, nonhospital setting.

All FQHC and RHC facilities are required to submit fee-for-service claims for valid medical encounters to the IHCP on the professional claim (*CMS-1500* claim form, Portal professional claim, or 837P transaction) using HCPCS encounter code **T1015**.

Additionally, claims for valid FQHC and RHC encounters must include one of the following place-of-service codes:

- 11 – *Office*
- 12 – *Home*
- 31 – *Skilled nursing facility*
- 32 – *Nursing facility*
- 50 – *Federally qualified health center*
- 72 – *Rural health clinic*

FQHC and RHC claims submitted with a place of service 11, 12, 31, 32, 50, or 72 that do not include the T1015 encounter code are denied for EOB 4121 – *T1015 must be billed with a valid CPT/HCPCS code*. Providers can resubmit these claims with the T1015 code properly included on the claim.

In addition to the T1015 encounter code, FQHC and RHC providers must include all Current Procedural Terminology (CPT®[†]) and HCPCS procedure codes appropriate to the services provided during the visit. For claims containing the T1015 encounter code, the claim logic compares the other procedure codes used

[†] *CPT copyright 2020 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

to a list of valid procedure codes approved by the Family and Social Services Administration (FSSA) as meeting criteria for the encounter code, and adjudicates the claim as follows:

- If the claim contains one of the allowable procedure codes from the encounter criteria, all procedure codes other than the T1015 encounter code are denied for explanation of benefits (EOB) 6096 – *The CPT/HCPCS code billed is not payable according to the PPS reimbursement methodology*, and the encounter rate (T1015) is reimbursed according to the usual and customary charge (UCC) established by Myers and Stauffer from the provider-specific rate on the provider file. The provider should not resubmit procedure codes separately that were denied for EOB 6096.
- If the claim does not contain any of the allowable procedure codes from the encounter criteria, the entire claim is denied for EOB 4124 – *The CPT/HCPCS code billed is not a valid encounter*. Providers should not resubmit claims denied for EOB 4124 for payment.

See the Myers and Stauffer website at mslc.com/Indiana for a complete list of CPT and HCPCS procedure codes that meet the criteria for a valid FQHC or RHC encounter. The list is reviewed periodically to account for new or end-dated CPT and HCPCS codes.

> *Note: When billing valid encounters provided by **telemedicine**, FQHC and RHC providers must use POS code 11, 12, 31, 32, 50, or 72 with the T1015 encounter code as usual. However, they should use POS code 02 (and modifier 95) with the CPT codes for the allowable services provided during the telemedicine encounter. See the Telemedicine and Telehealth Services module for details.*

Encounters on Consecutive Dates of Service

Providers can bill only one unit of T1015 on a single detail line of the claim. Providers should break down consecutive service dates so that they bill each day on a separate line.

Multiple Encounters on the Same Date of Service

The IHCP allows reimbursement for only one encounter code (T1015) per IHCP member, per billing provider, per day, unless the primary diagnosis code differs for the additional encounters. Multiple encounter claims from an FQHC or RHC for a member on the same date of service that do not include a different primary diagnosis code are denied for EOB 5000 or 5001 – *This is a duplicate of another claim*.

If a member visits an office twice on the same day with two different diagnoses, a second claim can be submitted for the second visit, using a separate claim form or electronic claim submission. However, this policy does not allow a provider to bill multiple claims for a *single* visit with multiple diagnoses by separating the diagnoses on different claims.

When two valid practitioners, such as a medical provider and a mental health provider, see the same patient in the same day, the principal diagnoses should not be the same.

> *Note: FQHCs and RHCs must strictly follow proper billing guidelines when submitting multiple diagnosis codes on a single claim. Diagnosis codes must be listed according to their importance, with the first code being the primary diagnosis – that is, the one that most strongly supports the medical necessity of the service:*
>
> - *The diagnosis code submitted in field 21A on the CMS-1500 claim form is considered the primary diagnosis for determining duplicate claims.*
> - *In the Portal, the first code entered in the Diagnosis Codes field is the primary diagnosis.*
> - *For 837P electronic transactions, the first diagnosis code entered in the Loop 2300 HI segment (H101) is the primary diagnosis.*

Services Provided outside a Valid Encounter

Services such as drawing blood, collecting urine specimens, performing laboratory tests, taking x-rays, filling and dispensing prescriptions, or providing optician services do not, in and of themselves, constitute encounters. Providers can include these services in the encounter reimbursement when they are performed in conjunction with an office visit with a qualifying practitioner. The IHCP does not reimburse for these services through claim submission if performed *without* a face-to-face visit with a qualifying practitioner.

FQHC and RHC rates include payment for the vaccine and administration fee, and these services cannot be billed separately. These services can be included in the encounter reimbursement when performed in conjunction with an office visit to a valid provider. These services are not reimbursable through claim submission if performed without a face-to-face visit with a qualifying practitioner.

For services provided at FQHCs or RHCs that are not valid encounters with a qualifying practitioner (such as injections performed by a nurse without a corresponding visit to satisfy the valid encounter definition), reimbursement is included in the PPS rate because the cost of the service is included in the facility's cost report. FQHCs and RHCs should contact Myers and Stauffer for information about cost reports and managed care settlements.

Hospital Services

FQHCs and RHCs use the professional claim (*CMS-1500* or electronic equivalent) to bill the IHCP for medical services provided in **all** settings, including hospitals and other facilities that do not qualify as FQHC or RHC encounter settings. The claim must include the appropriate place-of-service code for the setting in which the service was delivered.

It is not necessary for FQHCs or RHCs to include the T1015 encounter code on claims with place-of-service codes 19 through 26 (urgent care facilities, on- and off-campus outpatient hospitals, inpatient hospitals, emergency rooms, ambulatory surgical centers, birthing centers, and military treatment facilities). The IHCP reimburses FQHCs and RHCs for claims with place of service codes 19 through 26 at the current reimbursement rate for each specific CPT or HCPCS code. The IHCP considers these services to be non-FQHC or -RHC services provided by a valid practitioner, but in a setting other than an FQHC- or RHC-qualifying place of service.

Dental Services

Providers should bill claims for dental services provided at an FQHC or RHC as a dental claim (*ADA 2012* paper claim form, Portal dental claim, or 837D transaction) using Current Dental Terminology (CDT®‡) codes. The T1015 encounter code should **not** be used on dental claims. Myers and Stauffer makes settlements and reconciles dental claims to the provider-specific PPS rate through annual reconciliations.

For more information about dental billing and coverage, see the following provider reference modules:

- The *Claim Submission and Processing* module for information about completing the *ADA 2012* dental claim form and submitting dental claims via the Portal
- The *Dental Services* module for information about IHCP dental coverage, billing, and reimbursement

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Medicaid Rehabilitation Option Services

IHCP reimbursement for Medicaid Rehabilitation Option (MRO) services is available only when the services are billed by an IHCP-enrolled community mental health center (CMHC). MRO services are not reimbursed when billed under the FQHC or RHC provider specialties.

Because a number of FQHC facilities are operated by CMHCs, the IHCP allows such facilities to enroll separately as both an FQHC and a CMHC for the purposes of MRO billing. Any MRO services provided at the facility must be billed under the CMHC Provider ID, and following the normal MRO billing procedures, as described in the *Medicaid Rehabilitation Option Services* module.

The *Non Reimbursable Costs* section of the FQHC cost report has been updated to include a line for MRO services. FQHC providers must include nonreimbursable costs associated with MRO services provided at their facility in all cost reports. This information is used for calculating prospective payment reimbursement rates.

> *Note: In a clinic where FQHC and CMHC providers render services, the FQHC provider must include their separate place of service (POS) code when billing.*

Crossover Claims for Dually Eligible Members

The IHCP excludes all FQHC and RHC Medicare crossover claims from the PPS logic, as well as the crossover reimbursement methodology, and continues to pay coinsurance or copayment and deductible amounts for dually eligible (Medicare and Medicaid) members.

When submitting claims to Medicare, FQHCs and independent RHCs use the institutional claim (*UB-04* claim form or electronic equivalent). The IHCP accepts the institutional claim type for FQHC and RHC claims that cross over ***automatically*** from the Medicare payer to the IHCP. However, FQHCs and RHCs **must** use the professional claim (*CMS-1500* claim form or electronic equivalent) to submit Medicare-processed claims that did ***not*** automatically cross over to the IHCP, including claims allowed by Medicare that failed to cross over as well as Medicare-denied claims.

FQHC and RHC crossover claims submitted to the IHCP with place of service 11, 12, 31, 32, 50, or 72 must contain the T1015 encounter code and the CPT or HCPCS codes for the services rendered.

> *Note: All professional crossover claims submitted to the IHCP must show Medicare as the previous payer and must include the Medicare-paid amount (actual dollars received from Medicare) as well as Medicare deductible and coinsurance or copayment information at both the header (claim) and detail (service) level. If submitting the claim on a paper form, billers must include a completed IHCP TPL/Medicare Special Attachment Form, available on the Forms page at in.gov/medicaid/providers. If Medicare denied the claim, providers must attach the Explanation of Medicare Benefits (EOMB). For additional information about Medicare crossover billing, see the Claim Submission and Processing module.*

Third-Party Liability

All third-party liability (TPL), patient or waiver liability, and copayments apply, as appropriate, to FQHC and RHC services. Allowable EPSDT and pregnancy services provided during an encounter and appropriately billed bypass TPL. See *Prenatal and Preventive Pediatric Care Diagnosis Codes That Bypass Cost Avoidance* on the *Code Sets* page at in.gov/medicaid/providers.

The IHCP applies previous TPL payments at the detail level. See the *Third-Party Liability* module for general information about TPL.

Managed Care Considerations

FQHCs and RHCs can participate with a managed care entity (MCE). The MCE provider contract must specify the contractual arrangements to ensure that the FQHC or RHC is reimbursed for services. Claims for members in a managed care plan such as Hoosier Care Connect, Hoosier Healthwise, or the Healthy Indiana Plan (HIP) must be billed in the manner applicable to the specific MCE, and submitted to the MCE for processing. FQHC and RHC providers should use CPT codes to bill claims for members in managed care. Do not include the T1015 encounter code on managed care claims.

Myers and Stauffer reconciles all managed care claims to the provider-specific PPS rate and makes annual settlements. Providers may submit requests for supplemental payment to Myers and Stauffer. The MCEs must also provide data related to annual reconciliations to Myers and Stauffer.